Allergy and Asthma Associates of Allen
PF – 100 Notices of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONS ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment

Your health information may be used by staff member or disclosed to other health care professionals for the purpose of evaluation your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialist share you medical information with us. Also, we may provide your primary care physician and other specialist with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory testes and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment

Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services, For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Operations

Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement

Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with governmental mandated reporting.

Public Health Reporting

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state’s public health department.

Research

Under certain circumstance, we may use and disclose Health Information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one mediation or treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. This process evaluates a proposed research project and its use of Heath Information to balance the benefits of research with the need for privacy of Health Information. We also may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purpose.

Other Uses and Disclosures Require your Authorization

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders

Your Health information will be used by our staff to send you appointment reminders via the telephone, electronic mail, and/or the US mail.

Information about Treatments

Your health information may be used to send you information that your may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the sue and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive and accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Practice Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required by law to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulation. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to requests access to your medical records by contacting the receptionist or privacy officer. Your request will be reviewed and will generally be approved unless there is a legal or medical reason to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address show below. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to that address show below. Your will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
Hari Reddy, D.O., FAAAAI, FACAAAI
977 Raintree Circle, Ste 100
Allen, Texas 75013
972-747-7007

Effective Date
This Notice is effective on or after January 15, 2014

Allergy & Asthma Associates of Allen

Patient: ____
Last First MI

Address: ____
Street City State Zip

Home Telephone: ___________________________________Cell Phone: ______________________________

Social Security#: ________________________________Driver's License #: ______________________________

Date of Birth: _______________________________________Age: _______________Gender: ( ) Male ( ) Female

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Other

Employer: ____Work#: __________________________

Work Address: ____Email: __________________________

In case of emergency notify: ____

Relationship: ___________________Telephone#: ____________________Alternate#: ______________________

Primary Insurance Company: ____

Name of Insured: ____Relationship to Patient: ________________

Identification #: ______________________________________Group #: ______________________________

Insured's Date of Birth: ____________________Insured's Employer: _____________________________________

Insurance Telephone Number (Benefits line or Member's Services): ____

Who is your PRIMARY CARE PHYSICIAN? ____

Who referred you to our office? ____

FINANCIAL AGREEMENT AND AUTHORIZATION OF TREATMENT

I understand that I am required to give my current insurance card, driver's license, and billing information for insurance to be filed on my behalf. I also understand that I will notify Allergy & Asthma Associates of Allen of any changes in my insurance or billing information. If accurate billing and insurance information is not given then I will be responsible for all charges incurred due to timely filing requirements by my insurance company. I am also responsible for services denied by my insurance company as "non-covered" or "not medically necessary." I authorize the treatment of the person named above and agree to pay for all fees for such treatment. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pending of such claims and that all proceeds of insurance will be assigned to this office. I authorize the release of any medical information necessary to process insurance claims and also request payment of Government benefits either to me or the party that accepts assignment below.

Signature on File: ____Date: ______________________

Relationship to patient: ____

Allergy & Asthma Associates of Allen

Hari Reddy, D.O., FAAAAI, FACAAI 972-747-7007
Board Certified in Adult and Pediatric Allergy and Immunology Fax-972-747-7006
977 Raintree Circle, Suite 100
Allen, TX 75013

FINANCIAL OFFICE POLICY

Thank you for choosing our practice as your healthcare provider. Your clear understanding of our Financial Policy is important to our professional relationship. Please speak with the office manager if you have any questions regarding this policy.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE
Payment is required at the time services are rendered unless other arrangements have been made in advance. Such payments include coinsurance, co-payments, deductibles, and non-covered services for participating insurance companies. We accept cash and personal checks. There is a $25.00 service charge on all returned checks. If the patient is a minor, the parent/guardian who brings the child in for a visit is the responsible party.

INSURANCE
If we are contracted with your insurance company, we will file your charges for you. However, your insurance policy is a contract between you and your insurance company. It is important you understand its provisions. We cannot guarantee payment of your claims as the insurance companies only "quote" benefits, they never "guarantee" benefits. It is your responsibility to make sure we have your current insurance information so that we may correctly file your claims in a timely manner as all insurance companies have timely filing limitations. You will be required to show your insurance card at every visit for identification and to prevent insurance fraud. If we are not contracted with your insurance company, you will be required to pay in full at the time of service.

REFERRALS
If you are on an insurance plan that requires a referral, it is your responsibility to obtain a referral for your visits. The referral must be requested from your primary care physician prior to your appointment in order for insurance to be filed.

APPOINTMENTS
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. There will be a $25 fee for missed appointments.

FORMS/PRESCRIPTIONS
School/Camp/Physical forms may be mailed, faxed or dropped off to our office. We require 24-48 hour's notice for completion. We are happy to mail, fax or hold them for you to pick them up. For written prescriptions, please allow 48 hours for completion.

IMMUNOTHERAPY
All patients receiving allergy injections must wait in the waiting room at least 25 minutes following each injection. We do ask that you pay your co pay/coinsurance portion when you receive your injection. When a new vial of serum needs to be made, we do require you to clear any balance before processing the vial.

MEDICAL RECORDS
We are dedicated to keeping your medical records confidential and therefore require written authorization for release of medical records. Medical records will be completed within 15 business days as mandated by the Texas Board of Medical Examiners and may be subject to a processing fee as determined by the Board.

I have read and understand Allergy & Asthma Associates of Allen's Financial Policy. I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collection.

Signature of Responsible Party: ____Date: ____________________

Allergy & Asthma Associates of Allen

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice Reserves the right to modify the privacy practices outlined in this notice.
I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

____

Name of Patient (Print)

____

Signature of Patient

____

Date

____

Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign this form)

____

Relationship of Patient Representative to Patient

Allergy & Asthma Associates of Allen

Hari Reddy, D.O., FAAAAI, FACAAI
Board Certified in Adult and Pediatric Allergy and Immunology
977 Raintree Circle, Ste. 100, Allen, TX 75013

Medical History

Name: ____Date: ______________________

Gender: ( ) Male ( ) Female DOB: ____Age:____________________________

Who referred you to our office? ___________________________Primary Care Physician__________________________________

Reason for visit: ____

Duration of Condition: ____

Describe the most distressing symptoms you feel are caused by your allergy:
____
____
____
____
____

List all medications you have tried in the past for allergy (all oral, topical and nasal sprays) and the response you had to each:
____
____
____

Pharmacy, Address and Phone Number ____

Have you ever had allergy skin testing? ( ) Yes ( ) No

Date of testing: _________________________________Physician's name: ____

Have you ever been on allergy shots? ( ) Yes ( ) No Date(s): ____

Have you had sinusitis? ( ) Yes ( ) No Frequency: ____

Have you ever had a sinus X-ray or CT? ( ) Yes ( ) No Dates: ____

Have you ever been diagnosed with Asthma? ( ) Yes ( ) No

List family members with allergy problems: ____

Have you tested positive for ( ) HIV ( ) Hepatitis B ( ) Hepatitis C

Social History:

How long have you lived in Dallas? ____

How long have you lived in your current home? ______________Years ____________Months

Is there an obvious mold problem? ( ) Yes ( ) No Area of home: ____

Type of flooring (include bedroom): ______________________________

History of smoking: (   ) Yes (   ) No   How long? ____________   Packs per day: ____________

Prolonged cigarette smoke exposure: (   ) Yes (   ) No

Occupation: ______________________________

Hobbies: ______________________________

Pets: (   ) Dog (   ) Cat (   ) Other: ______________________________
(   ) Indoor (   ) Outdoor (   ) Both

Review of Systems: (please circle all symptoms you may have)

Headaches
Sinus pain
Eyes: Redness
Tearing
Itch
Puffiness
Nose: Colds
Discharge
Stuffiness
Hay fever
Itch
Bleeding
Sneezing
Snoring
Sinusitis
Ears: Frequent infection
Pain
Hearing loss
Chest: Asthma
Chronic cough
Shortness of breath
Bronchitis/pneumonia
Skin: Eczema
Contact dermatitis
Angioedema/Hives
Dry
Itchiness
Atopic dermatitis
GI: Nausea/vomiting
Appetite changes
Reflux symptoms
Lactose intolerance
Changes in bowel habits
GU: Infection
Incontinence
General: Weight loss/gain
Emotional problems
Sleep pattern
Missed school/work
Females: Abnormal menstrual periods
Menopause

Past Medical History

____

____

History of Surgery (include sinus surgery):

____

____

Known allergies to medications (List names and symptoms you had):

____

____

All current medications; please list dosage (include allergy medications):

____

____

____

(Women only)
Are you currently or might be pregnant? (   ) Yes (   ) No
Are you planning or attempting to become pregnant in the near future? ____________

Allergy & Asthma Associates of Allen

977 Raintree Circle, Ste 100 Allen, TX 75013
Telephone: 972-747-7007 Fax: 972-747-7006

ALLERGY SKIN TEST CONSENT FORM

The most often used method for skin testing is the skin prick test. This test exposes you to tiny amounts of items to which you may be allergic. If you are allergic to a substance a reaction will appear. The doctor and/or nurse will examine any bump that appears and the reddened area around it to decide whether a positive reaction has occurred indicating an allergy.

In the prick test, allergens are applied to tiny scratches that penetrate only the very top layer of skin and rarely draw blood. You may feel only a slight prick or scraping of the skin. If just a few tests are being given, the arm may be used. Reactions are usually seen in ten to thirty minutes if they are going to occur.

Reactions to testing can include an itchy rash that may last for several days and rarely (less than 1% of patients) – hives, swelling, sneezing, shortness of breath/anaphylaxis and light headedness.

The risk and benefits of allergy skin testing have been explained by my doctor and the staff. I am satisfied with the explanation that has been given and do not desire further information. I give permission and consent for this procedure and any treatment needed as a result of this procedure.

**IN ORDER TO AVOID COMPLICATIONS AND/OR INTERACTIONS PLEASE INFORM THE NURSE IF YOU HAVE HAD A MEDICATION CHANGE OR AN ADDITION TO YOUR REGIMEN SINCE THE PREVIOUS OFFICE VISIT.

______________________________ ______________________________

Patient Name (Please Print) Date

______________________________ ______________________________

Signature (Patient or Guardian) Witness